Results: 56 males, Age 57 years (32–86), divided into Group A (functional bowel disorders, n = 45) and Group B (preoperative assessment, n=11).
Group A included incontinence [AI] (n = 37), constipation (n = 3) & low anterior resection syndrome [LARS] (n = 5). Physiological diagnoses reached in AI are internal anal sphincter (IAS) and/or external anal sphincter (EAS) dysfunction and deranged rectal compliance. In 8 patients with AI, no physiological abnormalities were found. All patients with LARS had abnormal reservoir and IAS dysfunction and one had EAS injury. Group-B included patients seeking stoma closure (n = 6), three of whom were deemed unsuitable and preoperative assessment for recurrent anal disorders [n = 5; piles, (n = 1), fissure (n = 4)] one of whom had significant sphincteric injury.
Definitive diagnosis and decision were reached in 46 patients (82%).
Conclusion: ARP allowed objective assessment and decision making in majority of males presenting to a functional bowel service.

0772: LAPAROSCOPIC MANAGEMENT OF COLOVESICAL FISTULA: THE PREFERRED SURGICAL APPROACH?

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Aim: Colovesical fistula is an uncommon but severe complication of diverticular disease. To date, open surgical approach remains the standard treatment option. Although laparoscopic management for complicated diverticulitis has been shown to be effective in literature, there is scarce evidence about its role in the management of colovesical fistula. This is the largest European study which examine the feasibility and safety of laparoscopic management of colovesical fistula.
Methods: A single-centred retrospective analysis was performed on 16 consecutive patients with colovesical fistula who underwent one-stage laparoscopic excision of fistula, sigmoid resection and bladder reconstruction. Intraoperative and early postoperative complications (within 30 days) were recorded. Long-term outcomes were observed across a period of 12 months follow-up.
Results: Mean operating time was 193 ± 10.5 minutes and mean blood loss 140 ± 30.8 mL. Four were converted to open procedure with an associated longer hospital stay ($p < 0.01$). Mean total hospital stay was 10.2 days and median was 6. Fifteen (93.8%) patients had return of bowel function in 4 days. There was no reported anastomotic leak or bladder leak. There was no recurrence of fistula over 1 year. Mortality rate was zero.
Conclusion: Laparoscopic surgical treatment of diverticular colovesical fistula is feasible with no excess morbidity, in the setting of appropriate surgical expertise.

0904: THE USE OF INFLAMMATION-RELATED MARKERS TO PREDICT OUTCOME IN RECTAL CANCER

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Aim: In this study we aimed to analyse the usefulness of acute phase reactants to predict responses to NAT and other outcomes in rectal cancer.
Methods: We analysed prospectively maintained data of rectal cancer patients treated in the South East of Ireland from 2010-2014.Basic demographics, radiological and pathological features were tabulated. Neutrophil-lymphocyte ratio (NLR), platelet-lymphocyte ratio (PLR), serum-albumin(SAL) and CEA levels within 7 days prior to NAT were calculated. Tumour response to NAT was estimated based on TRG system of the American Joint Committee on Cancer 7thEd.Circumferential resection margin (CRM) was graded using AJCC scoring. Statistical analysis was performed using SPSS.
Results: 203 patients with rectal cancer were managed by the South-Eastern Rectal Cancer Network.61.7% of patients were male and 39.3% female.130 patients(64%) underwent surgery with curative intent of which 90% received NAT.14.3%(n = 17) achieved CPR following NAT,26.1%(n = 31)-TRG1,27.7%-TRG2,31.9%-TRG3.80.7% achieved an R0 resection(8.4% R1 and 2.5% R2).Elevated NLR was significantly associated with positive lymph nodes post-NAT($p = 0.027$)and lower chance of achieving R0 resection($p = 0.009$).Low SAL was predictive of not achieving an R0 resection($p = 0.004$)and elevated CEA was most predictive of positive post NAT lymph node positivity($p = 0.003$).
Conclusion: While inflammatory markers are predictive of CRM resection status and lymph node positivity post-NAT they alone do not predict overall tumour response to NAT and downstaging. Further research is warranted.

0906: CAN INFLAMMATORY MARKERS BE USED TO PREDICT COMPLETE PATHOLOGICAL RESPONSE IN RECTAL CANCER

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Aim: We sought to identify if baseline-inflammatory markers act as an adjunct to MRI for prediction of Complete Pathological Response.
Methods: We analysed data of rectal cancer patients treated in the South East of Ireland from 2010–2014.We identified patients who received NAT and achieved radiological or pathological CPR. Demographics, radiological and pathological features were tabulated. Neutrophil-lymphocyte ratio (NLR), platelet-lymphocyte ratio (PLR), serum albumin (SAL) and CEA levels within 7 days prior to NAT were calculated. Tumour response to NAT was estimated based on TRG system of the AJCC7th Ed. Association between post-operative CPR and raised inflammatory markers was analysed.
Results: 203 patients with rectal cancer were managed by the South Eastern Rectal Cancer Network. 24 patients achieved radiological (MRI) or pathological CPR. Mean age was 67.1 years (range 59–80), a 1:3 female:-male ratio was observed.62.5%(n=15)of patients were tumour stage3 on pre-NAT MRI,12.5% (n = 3) were T4.All patients received chemo/radiotherapy. NLR ($p=0.43$), PLR ($p=0.34$), SAL ($p=0.64$) and CEA ($p=0.32$) alone were not predictive of CPR. In this sample group 7patients (29.2%) had CPR on MRI but remnant disease following surgical excision (4 = T3, 3 = T2).Correlation of post-NAT MRI and post-operative histology was not significant in this small sample size ($p = 0.235$).However, when raised NLR is considered with post-NAT MRI CPR, it is significantly associated with histological-CPR ($p = 0.042$).
Conclusion: Raised NLR and complete pathological response on post-NAT MRI is more predictive than MRI alone for histological CPR in rectal cancer patients following NAT.

0931: LAPAROSCOPIC VERSUS OPEN T4 COLONIC CANCER RESECTION

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Aim: The role of laparoscopic resection in T4 colon cancer is controversial, with the early laparoscopic randomised trials reporting variable outcomes in this cohort of patients. We aim to examine the clinical and oncological outcomes between laparoscopic and open T4 colon cancer resections.
Methods: All consecutive patients undergoing surgery for a radiological presumed T4 colon cancer between 2009 and 2012 from a prospectively maintained database were identified. Data were collected on patient demographics, operative detail, histological data and follow up status.
Results: 221 patients were identified, with 106 (48.0%) undergoing open surgery and 115 (52.0%) undergoing laparoscopic surgery. Conversation rate was 12.1%. The two groups were similar in pre-operative staging. R0 resection rate was achieved in 75.9% with similar rates in the laparoscopic and open group, 40.8% and 35.1% respectively, $p = 0.74$. Complication rates were similar between the two groups (laparoscopic 19% versus open 23.5%, $p = 0.06$). Median length of stay was shorter in the laparoscopic group compared to the open group (9 versus 14 days, $p = 0.05$). Overall 3-year survival was similar in both groups, (laparoscopic 39% versus open 25%, $p = 0.27$).
Conclusion: Laparoscopic surgery is feasible in T4 colon cancers with comparable clinical and oncological outcomes, with the advantage of faster recovery.

0945: T4 COLON CANCERS – ELECTIVE VERSUS EMERGENCY IN THE MODERN ERA